

02485

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

2498

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <u>Caroline</u>  | MARYLAND   | STATE <u>Maryland</u>  | COUNTY <u>Caroline</u>                               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Rural Denton</u>  | LENGTH OF STAY (in this place)<br><u>50 Yrs.</u> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Rural Denton</u>   | <u>X</u>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>None</u>  |  | STREET ADDRESS (If rural give location)<br><u>None</u>   | <u>1</u>   |
| 3. NAME OF DECEASED:  |  | 4. DATE (Month) (Day) (Year)   |  |
| (First) <u>John</u>   | (Middle)   | (Last) <u>Baynard Sr.</u>  | DATE OF DEATH: <u>3</u> <u>4</u> <u>55</u> <u>19</u> |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u>                   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  | 8. DATE OF BIRTH: <u>2/14/1878</u>                   |
| 9. AGE last birthday: <u>77</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, so state): <u>Retired Farm Owner</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>   |  |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME: <u>John Baynard</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Mary Ann Hurd</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>  |  | 16. SOCIAL SECURITY NO.: <u>215-26-2778</u>  |  |
| 17. INFORMANT & ADDRESS: <u>Landa Baynard Denton, Md.</u>   |  |  |  |
| 18. MEDICAL CERTIFICATION   |  |  | INTERVAL BETWEEN ONSET AND DEATH                     |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |
| IMMEDIATE CAUSE (A) <u>420.1 acute coronary occlusion</u>   |  |  | <u>five minutes</u>                                  |
| ANTECEDENT CAUSE (B)  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |  |
| (C)   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerosis</u>  |  |  | <u>5 years</u>                                       |
| 19A. DATE OF OPERATION:   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
|   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  |
|   |  | 21C. WHERE DID (City or town) (Country) (State)  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
|   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>Nov 29</u> , 19 <u>44</u> , to <u>March 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above. |  |  |  |
| SIGNATURE <u>Paul Throth</u>  |  | DATE SIGNED <u>3-5-55</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | DATE THEREOF <u>3/7/55</u>   |  |
| NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>   |  | LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>2/5/55</u>   |  | REGISTRAR'S SIGNATURE <u>Dr. D. O. George</u>  |  |
| 24. FUNERAL DIRECTOR <u>J. E. Boulais</u>   |  | ADDRESS <u>Greensboro, Md.</u>   |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

MAR 10 1955

RECEIVED

2499

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH:  |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |   |  |
| COUNTY <i>Caroline</i>  |  | MARYLAND  |  | STATE <i>Maryland</i>   |  | COUNTY <i>Caroline</i>  |  |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Rural Denton</i>   |  | LENGTH OF STAY (in this place) <i>life</i>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>                               |  | X   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |  |   |  | STREET ADDRESS (If rural give location) <i>1</i>  |  |   |  |
| 3. NAME OF DECEASED: (Type or Print) <i>NANCY</i> (First) (Middle) (Last) <i>CORKRELL</i>   |  |   |  | 4. DATE OF DEATH: (Month) <i>MAR</i> (Day) <i>23</i> (Year) <i>1955</i>   |  |   |  |
| 5. SEX: <i>F</i>  |  | 6. COLOR OR RACE: <i>W</i>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>  |  | 8. DATE OF BIRTH: <i>1901</i>                                   |  |
| 9. AGE last birthday: <i>54</i> yrs.  |  | IF UNDER 1 YEAR: Months Days Hours Min.   |  | 10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>housewife</i>              |  | 11. BIRTHPLACE (State or foreign country): <i>Danvers</i>       |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |  |   |  | 13. FATHER'S NAME: <i>China Thomas</i>  |  |   |  |
| 14. MOTHER'S MAIDEN NAME: <i>Lida Porter</i>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <i>no</i> (If Yes, give war or dates of service) <i>-</i> |  |   |  |
| 16. SOCIAL SECURITY No.: <i>-</i>   |  |   |  | 17. INFORMANT & ADDRESS: <i>Mrs. John Corkrell, Denton, Ind.</i>  |  |   |  |
| 18. MEDICAL CERTIFICATION   |  |   |  |   |  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |  |   |  |   |  |
| 442X Immediate cause (a) <i>Cerebral Hemorrhage</i>   |  |   |  |   |  |   |  |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Arteriosclerotic Disease &amp; Hypertension</i>  |  |   |  |   |  |   |  |
| (c) <i>Chr. Chole Cystitis</i>  |  |   |  |   |  |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chr. Chole Cystitis</i>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION:   |  |   |  | 19b. MAJOR FINDINGS OF OPERATION  |  |   |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 21. ACCIDENT (Specify)  |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  | (CITY OR TOWN)  |  | (COUNTY) (STATE)  |  |
| SUICIDE   |  | HOMICIDE  |  | INJURY  |  |   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>Sept. 8, 1954</i> , to <i>Mar. 23, 1955</i> , that I last saw the deceased alive on <i>Mar. 22, 1955</i> , and that death occurred at <i>Denton, Ind.</i> from the causes and on the date stated above. |  |   |  |   |  |   |  |
| SIGNATURE <i>Charles H. Streeter MD</i>   |  | (Degree or title)   |  | ADDRESS <i>Peaces bro. Rd. Dec. 24 1955</i>   |  | DATE SIGNED   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |  | DATE THEREOF <i>Mar. 25, 1955</i>   |  | NAME OF CEMETERY OR CREMATORY <i>Burrville</i>  |  | LOCATION (City, town, or county) (State) <i>Burrville, Ind.</i> |  |
| DATE REC'D BY LOCAL REGISTRAR <i>3/25/55</i>  |  | REGISTRAR'S SIGNATURE <i>Wm S O'Geary</i>   |  | 24. FUNERAL DIRECTOR <i>J. Angel Moore Son, Denton</i>  |  | ADDRESS   |  |

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MAR 29 1955

BUREAU V. S.

02487

MARYLAND

2570

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Caroline</u> MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Kent</u>     |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1st Ave. West. extended</u>   |  | STREET ADDRESS (If rural, give location) <u>14X-2</u>                                  |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Edgar Nelson Cully</u>   |  | 4. DATE OF DEATH<br>(Month) <u>March</u> (Day) <u>21</u> (Year) <u>1953</u>            |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>W.</u>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify) <u>Widowed</u>                     | 8. DATE OF BIRTH<br><u>Mar. 10 1873</u>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Printing</u>                                   | 9. AGE last birthday<br><u>82</u> yrs.                              |
| 11. BIRTHPLACE (State or foreign country)<br><u>Kent Co. Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |   |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Shinn</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)   |  | 16. SOCIAL SECURITY No.<br><u>None</u>   |   |
| 17. INFORMANT AND ADDRESS<br><u>Mrs. Claudia Guthrie - Ridgely Ind.</u>  |  |  |   |
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>During Sleep</u>                                |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |   |
| 420.1 Immediate cause (a) <u>Chronic coronary thrombosis</u>   |  |  |   |
| Antecedent cause(s) (b) <u>Hypertension - myocardial infarction</u>  |  |  |   |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis - cerebral arteriosclerosis</u>   |  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |   |
| 19a. DATE OF OPERATION   | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>    |   |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY  | (CITY OR TOWN)   | (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR?<br><u>March 2, 1955</u>  |   |
| 22. I hereby certify that I attended the deceased from <u>March 2, 1955</u> to <u>March 4, 1955</u> , that I last saw the deceased alive on <u>March 4, 1955</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. |  |  |   |
| SIGNATURE <u>Charles H. Winkler</u> (Deputy or title)  |  | ADDRESS <u>Ridgely, Md. Mar. 21, 1955</u>  |   |
| 23. BURIAL, CREMATION REMOVAL (Specify)  | DATE <u>3/23/55</u>  | NAME OF CEMETERY OR CREMATORY <u>Wash. Chapel Cemetery</u>                             | LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u> |
| DATE REC'D BY LOCAL REG.   | REGISTRAR'S SIGNATURE <u>Mary G. Baird</u>   | 24. FUNERAL DIRECTOR <u>Marvin V. Williamson - Cheltenham Ind.</u>                     |   |

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BUREAU V. S.

MAR 23 1955

RECEIVED

2501

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH:   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <b>Caroline</b>   | MARYLAND  | STATE <b>Maryland</b>  | COUNTY <b>Caroline</b>                                 |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>Preston</b>   | LENGTH OF STAY (in this place)<br><b>50 years</b> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Preston</b>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>00</b>   |   | STREET ADDRESS (If rural give location)<br><b>1</b>  |  |
| 3. NAME OF DECEASED:   |   | 4. DATE OF DEATH:  |  |
| (First) <b>Peter</b>   | (Middle)  | (Last) <b>deWilde</b>  | (Month) <b>March</b> (Day) <b>1</b> (Year) <b>1955</b> |
| 5. SEX: <b>Male</b>  | 6. COLOR OR RACE: <b>White</b>                    | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>   | 8. DATE OF BIRTH: <b>May 24, 1877</b>                  |
| 9. AGE last birthday: <b>77</b> yrs.   |   | 10. IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>   |  |
| 11. BIRTHPLACE (State or foreign country): <b>Holland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME: <b>Cornelius deWilde</b>  |   | 14. MOTHER'S MAIDEN NAME: <b>Dina Bustraan</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 17. INFORMANT & ADDRESS: <b>Mrs. Maria deWilde, Preston, Maryland</b>  |   |  |  |
| 18. MEDICAL CERTIFICATION  |   |  | INTERVAL BETWEEN ONSET AND DEATH                       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |  |  |
| IMMEDIATE CAUSE (A) <b>Chronic Congestive Heart Failure</b>  |   |  | <b>2 yrs</b>   |
| ANTECEDENT CAUSE (S) (B) <b>1st Term Chronic Heart Disease</b>   |   |  | <b>10 yrs</b>  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.   |   |  |  |
| (C)  |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   |  |  |
| 19A. DATE OF OPERATION:  |   | 19B. MAJOR FINDINGS OF OPERATION   |  |
|  |   |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |  |
|  |   | 21C. WHERE DID (City or town) (County) (State)   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
|  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/10</b> , 19 <b>58</b> , to <b>3/1</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>3/1</b> , 19 <b>55</b> , and that death occurred at <b>10:45 P</b> , from the causes and on the date stated above. |   |  |  |
| SIGNATURE <b>James D. Plummer</b>  |   | DATE SIGNED <b>3/3/55</b>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |   | DATE THEREOF <b>March 4, 1955</b>  |  |
| NAME OF CEMETERY OR CREMATORY <b>Linchester Cemetery</b>   |   | LOCATION City, town, or county (State) <b>Preston, Maryland</b>  |  |
| DATE REC'D BY LOCAL REGISTRAR <b>3-4-55</b>  |   | 24. FUNERAL DIRECTOR ADDRESS <b>J.J. Frampton and Son, Federalsburg, Md.</b>   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1955

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|  |  |   |                                       |
|--|--|---|---------------------------------------|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                                       |
| COUNTY <u>Caroline</u>   | MARYLAND                                     | STATE <u>Maryland</u>   | COUNTY <u>Caroline</u>                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Denton</u>   | LENGTH OF STAY (in this place) <u>30 yrs</u> | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>         |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>  |  | STREET ADDRESS (If rural give location)   |                                       |
| 3. NAME OF DECEASED: (First) <u>MARTHA</u> (Middle) <u>STEPHANIE</u> (Last) <u>HENNINGS</u>  |  | 4. DATE OF DEATH: (Month) <u>Mar</u> (Day) <u>18</u> (Year) <u>55</u>                             |                                       |
| 5. SEX: <u>F</u>   | 6. COLOR OR RACE: <u>W</u>                   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>                                   | 8. DATE OF BIRTH: <u>Dec 26, 1872</u> |
| 9. AGE last birthday: <u>82</u> yrs.   |  | 10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                    |                                       |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>home</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                                       |
| 13. FATHER'S NAME: <u>Henry Hoffman</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Lufkinson</u>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>   |  | 16. SOCIAL SECURITY No.: <u>—</u>   |                                       |
| 17. INFORMANT & ADDRESS: <u>Mrs. Boyd Reisel, Denton, Md.</u>  |  |   |                                       |
| 18. MEDICAL CERTIFICATION  |  |   |                                       |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | Interval Between Onset And Death  |                                       |
| <u>1450.0</u>  |  | <u>12 years</u>   |                                       |
| Immediate cause (a) <u>arterio sclerosis</u>   |  | <u>8 years</u>  |                                       |
| Antecedent causes (b) <u>Parkinsons Disease</u>  |  |   |                                       |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)  |  |   |                                       |
| 11. OTHER SIGNIFICANT CONDITIONS   |  |   |                                       |
| Conditions contributing to the death but not related to the disease or condition causing death.  |  |   |                                       |
| 19a. DATE OF OPERATION:  |  | 19b. MAJOR FINDINGS OF OPERATION  |                                       |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |   |                                       |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |                                       |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                       |
| HOW DID INJURY OCCUR?  |  |   |                                       |
| 22. I hereby certify that I attended the deceased from <u>Feb 18</u> , 19 <u>55</u> , to <u>March 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>55</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. |  |   |                                       |
| SIGNATURE <u>Stuart M. A. George</u>   |  | DATE SIGNED <u>3-21-55</u>  |                                       |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | DATE THEREOF <u>Mar. 21, 1955</u>   |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Denton</u>  |  | LOCATION (City, town, or county) (State) <u>Denton, Md.</u>                                       |                                       |
| DATE REC'D BY LOCAL REGISTRAR <u>3/21/55</u>   |  | REGISTRAR'S SIGNATURE <u>Stuart M. A. George</u>  |                                       |
| 24. FUNERAL DIRECTOR <u>J. Vigil</u>   |  | ADDRESS <u>Wheaton, Denton, Md.</u>   |                                       |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1955

BUREAU V. S.

2533

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |   |  |
| COUNTY <u>Caroline</u>   |  | MARYLAND   |  | STATE <u>Maryland</u> COUNTY <u>Caroline</u>  |  |   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |  | LENGTH OF STAY (In this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Greensboro</u>           |  | <u>X</u>  |  |
| <u>X</u> TOWN <u>Rural Greensboro</u>  |  | <u>51 Yrs.</u>   |  | STREET ADDRESS (If rural give location)   |  | <u>None</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>  |  |  |  |   |  |   |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |  |  |  | 4. DATE (Month) (Day) (Year)  |  |   |  |
| <u>George Joseph Kibler</u>  |  |  |  | <u>3 6 55 19</u>  |  |   |  |
| 5. SEX: <u>Male</u>  |  | 6. COLOR OR RACE: <u>White</u>   |  | 7. SINGLE. MARRIED. WIDOWED. DIVORCED. <u>Single</u>  |  | 8. DATE OF BIRTH: <u>8/27/1903</u>                                    |  |
| 9. AGE last birthday: <u>51</u> yrs.   |  | IF UNDER 1 YEAR: Months Days Hours Min.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Laborer</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>                        |  |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |
| 13. FATHER'S NAME: <u>Louis Kibler</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Schreiber</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>214-30-7985</u>  |  | 17. INFORMANT & ADDRESS: <u>Anne Bradford Greensboro, Md.</u>         |  |
| 18. MEDICAL CERTIFICATION  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |  |   |  |   |  |
| 57 <u>acute myocarditis</u>  |  |  |  |   |  | <u>4 hrs.</u>   |  |
| IMMEDIATE CAUSE (A) DUE TO   |  |  |  |   |  |   |  |
| ANTECEDENT CAUSE (B) DUE TO  |  |  |  |   |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Viral enteric infection</u>   |  |  |  |   |  | <u>4 hrs.</u>   |  |
| (C) <u>E. coli (fecal oral)</u>  |  |  |  |   |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Mar. 6, 1955</u> to <u>Mar. 6, 1955</u> that I last saw the deceased alive on <u>Mar. 6, 1955</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. |  |  |  |   |  |   |  |
| SIGNATURE <u>Charles H. Masser</u>   |  | M.D.   |  | ADDRESS <u>Greensboro, Md.</u>  |  | DATE SIGNED <u>March 7, 1955</u>                                      |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>3/9/55</u>   |  | NAME OF CEMETERY OF CREMATORY <u>Holy Cross</u>   |  | LOCATION (City, town, or county) (State) <u>Near Greensboro, Md.</u>  |  |
| DATE REC'D BY LOCAL REGISTRAR: <u>Mar. 9, 1955</u>   |  | REGISTRAR'S SIGNATURE <u>L. M. Pappin</u>  |  | 24. FUNERAL DIRECTOR <u>J. E. Boulaire</u>  |  | ADDRESS <u>Greensboro, Md.</u>  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

R 11 1955



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ~~me~~ is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02491

2524

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <u>Caroline</u>   |  | MARYLAND                                   |  | STATE <u>Maryland</u>  |  | COUNTY <u>Caroline</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)             |  | CITY (If outside corporate limits, write RURAL and give nearest town)  |  |   |  |
| <input checked="" type="checkbox"/> TOWN <u>Rural Ridgely</u>  |  | <u>66 Yrs.</u>                             |  | <input checked="" type="checkbox"/> TOWN <u>Rural Ridgely</u>  |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>  |  |  |  | STREET ADDRESS (If rural give location) <u>None</u>  |  |   |  |
| 3. NAME OF DECEASED: (Type or Print)   |  |  |  | 4. DATE OF DEATH:  |  |   |  |
| (First) <u>Marshall</u> (Middle) <u>Francis</u> (Last) <u>Lockman</u>  |  |  |  | DATE (Month) <u>3</u> (Day) <u>6</u> (Year) <u>55</u>  |  |   |  |
| 5. SEX. <u>Male</u>  |  | 6. COLOR OR RACE. <u>Col.</u>              |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>  |  | 8. DATE OF BIRTH: <u>7/15/1888</u>  |  |
|  |  |  |  | 9. AGE last birthday: <u>66</u> yrs.   |  | 10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, if deceased) <u>Farm Laborer</u>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>   |  | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>                  |  |
| 13. FATHER'S NAME: <u>Cherry Lockman</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>Mary Armstrong</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>  |  |  |  | 16. SOCIAL SECURITY No. <u>218-09-5825</u>   |  | 17. INFORMANT & ADDRESS: <u>Hattie Lockman Ridgely, Md.</u>                 |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 44 - X IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u>   |  |  |  |  |  |   |  |
| ANTECEDENT CAUSE (B) <u>Cerebral General Arteriosclerosis</u>  |  |  |  |  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>  |  |  |  |  |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>   |  |  |  |  |  |   |  |
| 19A. DATE OF OPERATION: <u></u>  |  |  |  | 19B. MAJOR FINDINGS OF OPERATION: <u></u>  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>  |  |  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? <u></u>  |  |
| 22. I hereby certify that I attended the deceased from <u>Nov. 22, 1954</u> , to <u>Mar. 6, 1955</u> , that I last saw the deceased alive on <u>Mar. 5, 1955</u> , and that death occurred at <u>5 A. M.</u> from the causes and on the date stated above. |  |  |  |  |  |   |  |
| SIGNATURE <u>[Signature]</u>   |  |  |  | ADDRESS <u>Breensboro Md.</u>  |  | DATE SIGNED <u>Mar. 7, 1955</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  |  |  | DATE THEREOF <u>3/9/55</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Denton</u>                                 |  |
|  |  |  |  |  |  | LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>            |  |
| DATE REC'D BY LOCAL REGISTRAR <u>3/9/55</u>  |  | REGISTRAR'S SIGNATURE <u>Mary E. Laird</u> |  | FUNERAL DIRECTOR <u>J. E. Boulaie</u>  |  | ADDRESS <u>Breensboro, Md.</u>  |  |

7 22 0578101

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2505

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>Caroline</u>   | MARYLAND   | STATE <u>Maryland</u>  | COUNTY <u>Caroline</u>                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Greensboro</u>   | LENGTH OF STAY (in this place)<br><u>75 Yrs.</u>   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Greensboro</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>None</u>   | STREET ADDRESS (If rural give location)<br><u>None</u>   |  |   |
| 3. NAME OF DECEASED:   |  | 4. DATE (Month) (Day) (Year)   |   |
| (First) <u>Frank</u>   | (Middle) <u>Finch</u>  | (Last) <u>Manship</u>  | DATE OF DEATH: <u>3</u> <u>25</u> <u>55</u> <u>19</u> |
| 5. SEX: <u>Male</u>  | 6. COLOR OR RACE: <u>White</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>  | 8. DATE OF BIRTH: <u>1/3/1880</u>                     |
| 9. AGE last birthday: <u>75</u> yrs.   |  | 10. IF UNDER 1 YEAR: Months Days Hours Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):<br><u>Machine Shop Pet Milk Co.</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY:<br><u>None</u>  |   |
| 11. BIRTHPLACE (State or foreign country):<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME:<br><u>Andrew Manship</u>  |  | 14. MOTHER'S MAIDEN NAME:<br><u>Lida Tinley</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.:<br><u>217-05-7885</u>   |   |
| 17. INFORMANT & ADDRESS:<br><u>Cora Manship Greensboro, Md.</u>  |  |  |   |
| 18. MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |   |
| IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease</u>   |  |  |   |
| ANTECEDENT CAUSE (B) <u>General Arteriosclerosis</u>   |  |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |   |
| (C) <u>Coronary Sclerosis</u>  |  |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |   |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |   |
|  |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                       |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>Nov. 22, 1954</u> to <u>Mar. 25, 1955</u> , that I last saw the deceased alive on <u>Mar. 25, 1955</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above. |  |  |   |
| SIGNATURE <u>Carl H. Hines</u>   |  | DATE SIGNED <u>March 28, 1955</u>  |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | DATE THEREOF<br><u>3/29/55</u>   | NAME OF CEMETERY OR CREMATORY<br><u>Greensboro</u>    |
| LOCATION (City, town, or county) (State)<br><u>Greensboro, Md.</u>   |  |  |   |
| DATE REC'D BY LOCAL REGISTRAR<br><u>Mar 29-1955</u>  |  | REGISTRAR'S SIGNATURE<br><u>L. M. Lippin</u>   |   |
| FUNERAL DIRECTOR<br><u>J. E. Boulaie</u>   |  | ADDRESS<br><u>Greensboro, Md.</u>  |   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT V. S.

10/20/00  
P. 10

2506

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

COUNTY Caroline MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Newton Rd.  
 OR TOWN Newton Rd.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Newton Rd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Ind COUNTY Caroline  
 CITY (If outside corporate limits, write RURAL and give nearest town) Newton Rd.  
 OR TOWN Newton Rd.  
 STREET ADDRESS (If rural give location) Newton Rd.

## 3. NAME OF DECEASED:

(First) Edward (Middle) Parter (Last) Parter

4. DATE OF DEATH: (Month) Mar. (Day) 10 (Year) 1955

## 5. SEX:

M

## 6. COLOR OR RACE:

W.

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

Mar. 10 1881

## 9. AGE last birthday:

74 yrs.

If UNDER 1 YEAR: Months Days Hours Min.  
 If UNDER 24 HRS: Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Farmer

## 10b. KIND OF BUSINESS OR INDUSTRY:

Farmer

## 11. BIRTHPLACE (State or foreign country):

Ind. Newton Rd.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Charles Parter

## 14. MOTHER'S MAIDEN NAME:

Margaret Earnett

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

—

## 17. INFORMANT &amp; ADDRESS:

Chas. Parter, Newton

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421X  
 Immediate cause (a) Myocarditis Acute  
 DUE TO

## Antecedent causes (s)

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last.

(b) —  
 DUE TO

(c) —

Interval Between  
 Onset And Death

2 days

## II OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
 related to the disease or condition causing death.

Arteriosclerosis109m

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

—

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

INJURY OCCURRED  
 While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to Mar. 10, 1955, that I last saw the deceased

alive on 3-10, 1955, and that death occurred at 4:45 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Buried

DATE THEREOF

Mar. 15

NAME OF CEMETERY OR CREMATORY

Newton Cemetery

LOCATION (City, town, or county)

Newton

(State)

Ind.

DATE REC'D BY LOCAL REGISTRAR

Mar. 13-1955

REGISTRAR'S SIGNATURE

L. M. Pappas

FUNERAL DIRECTOR

J. Virgil Moore & Sons

ADDRESS

Newton

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

7 16 1955

RECEIVED

2507

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

02494

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <i>Caroline</i>   |  | MARYLAND  |  | STATE <i>Maryland</i>  |  | COUNTY <i>Caroline</i>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <i>Templeville</i>   |  | LENGTH OF STAY (in this place) <i>80 yrs.</i>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Templeville</i> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>  |  |   |  | STREET ADDRESS (If rural give location) <i>None</i>                                      |  |   |  |
| 3. NAME OF DECEASED. (First) (Middle) (Last) <i>ANNIE THOMPSON SATTERFIELD</i>   |  |   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <i>3 18 1955</i>                                  |  |   |  |
| 5. SEX: <i>F.</i>  |  | 6. COLOR OR RACE: <i>White</i>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>                                    |  | 8. DATE OF BIRTH: <i>10/3/1874</i>                                    |  |
| 9. AGE last birthday <i>80</i> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired, specify) <i>Housewife</i>     |  | 10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>   |  | 11. BIRTHPLACE (State or foreign country): <i>Maryland</i>            |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 13. FATHER'S NAME: <i>William Thompson</i>  |  | 14. MOTHER'S MAIDEN NAME: <i>Sarah Nickerson</i>   |  | 15. INFORMANT & ADDRESS: <i>Geo. Satterfield Templeville, Md.</i>     |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No or unk.) (If Yes, give war or dates of service) <i>No</i>  |  | 17. SOCIAL SECURITY NO. <i>None</i>   |  | 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (A) <i>My percutaneous Heart Disease</i>   |  |   |  | <i>5 yrs</i>   |  |   |  |
| ANTECEDENT CAUSE (B) <i>Generalized Arteriosclerosis</i>   |  |   |  | <i>10 "</i>  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |   |  |  |  |   |  |
| (C) <i>None</i>  |  |   |  |  |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION: <i>None</i>  |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | 21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <i>None</i>                                      |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>None</i>                 |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>No Injury</i> M.  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? <i>None</i>   |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>May 3/19 5-20</i> to <i>Mar 18, 1955</i> , that I last saw the deceased alive on <i>Mar 18, 1955</i> , and that death occurred at <i>5:40 P.M.</i> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| SIGNATURE <i>J.H. Hamilton</i>   |  |   |  | DATE SIGNED <i>3/19/55</i>   |  |   |  |
| M.D. <i>Hamilton Md</i>  |  |   |  |  |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | DATE THEREOF <i>3/21/55</i>   |  | NAME OF CEMETERY OR CREMATORY <i>Busic</i>   |  | LOCATION (City, town, or county) (State) <i>Near Templeville, Md.</i> |  |
| DATE REC'D BY LOCAL REGISTRAR <i>3/21/55</i>   |  | REGISTRAR'S SIGNATURE <i>A. Clark Smith</i>   |  | FUNERAL DIRECTOR <i>J.E. Boula's Greensboro, Md.</i>                                     |  | ADDRESS   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2578

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |  |
| COUNTY <u>Caroline</u>   |  | MARYLAND   |  | STATE <u>Maryland</u>   |  | COUNTY <u>Caroline</u>                   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |  |  |
| X TOWN <u>Rural Greensboro</u>   |  | 51 Yrs.  |  | OR TOWN <u>Rural Greensboro</u> X                                     |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  | None   |  | STREET ADDRESS (If rural give location)                               |  |  |  |
|  |  |  |  | None  |  |  |  |
| 3. NAME OF DECEASED:   |  |  |  | 4. DATE (Month) (Day) (Year)  |  |  |  |
| (First) (Middle) (Last)  |  |  |  | OF DEATH  |  |  |  |
| <u>Lawrence George Schreiber</u>   |  |  |  | <u>3 14 55 19</u>   |  |  |  |
| 5. SEX:  |  | 6. COLOR OR RACE:  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)                      |  | 8. DATE OF BIRTH:                        |  |
| Male   |  | White  |  | Married   |  | 3/20/1903                                |  |
| 9. AGE last birthday   |  | 10. BIRTHPLACE (State or foreign country):   |  | 11. CITIZEN OF WHAT COUNTRY?  |  | 12. IF UNDER 1 YEAR                      |  |
| 51 yrs   |  | Maryland   |  | U.S.A.  |  | Months Days Hours Min.                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY:                                    |  |  |  |
| Farm Owner   |  |  |  | None  |  |  |  |
| 13. FATHER'S NAME:   |  |  |  | 14. MOTHER'S MAIDEN NAME:   |  |  |  |
| <u>George P. Schreiber</u>   |  |  |  | <u>Josephine Brogely</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| No   |  |  |  | 220-12-5336   |  |  |  |
| 17. INFORMANT & ADDRESS:   |  |  |  | 18. MEDICAL CERTIFICATION   |  |  |  |
| <u>Kathryn Schreiber Greensboro, Md.</u>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u>  |  |  |  |   |  |  |  |
| ANTECEDENT CAUSE (B)   |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |  |   |  |  |  |
| (C)  |  |  |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  | <u>Malignant Hypertension</u>   |  |  |  |
| 19A. DATE OF OPERATION:  |  |  |  | 19B. MAJOR FINDINGS OF OPERATION                                      |  |  |  |
|  |  |  |  |   |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State)                        |  | INJURY OCCUR?                            |  |
|  |  |  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Oct. 15, 1954</u> , to <u>Mar. 14, 1955</u> , that I last saw the deceased alive on <u>Mar. 14, 1955</u> , and that death occurred at <u>12:20</u> , from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>Charles H. Huffer</u>   |  |  |  | ADDRESS <u>Greensboro, Md.</u>  |  | DATE SIGNED <u>March 17, 1955</u>        |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State) |  |
| Burial   |  | 3/17/55  |  | Holy Cross  |  | Greensboro, Md.                          |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |  | FUNERAL DIRECTOR  |  | ADDRESS                                  |  |
| <u>Mar. 17-1955</u>  |  | <u>L. M. Pappas</u>  |  | <u>J. E. Boulois</u>  |  | <u>Greensboro, Md.</u>                   |  |

MARGIN RESERVE FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FOR SALE

1/2

## CERTIFICATE OF DEATH

Reg. Dist. No. *62*1. PLACE OF DEATH *2599*COUNTY *Caroline* MARYLAND  
CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) *Newton, Rd. Libe*  
TOWN *Newton, Rd. Libe*HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Maryland* COUNTY *Caroline*  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN *Newton, Rd.*STREET ADDRESS (If rural give location)  
*1*3. NAME OF  
DECEASED:  
(Type or Print)*William Smith*4. DATE OF DEATH: (Month) (Day) (Year)  
*Mar. 15 1955*

## 5. SEX:

*M.*6. COLOR OR  
RACE:*W.*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): *Married*

## 8. DATE OF BIRTH:

*Aug. 3, 1877*

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

*77 yrs. 8 Months 15 Days 15 Min.*10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired:*Farmer*10b. KIND OF BUSINESS OR  
INDUSTRY:*Maryland*12. CITIES OF WHAT  
COUNTRY?*U.S.A.*

## 13. FATHER'S NAME:

*Charles F. Smith*

## 14. MOTHER'S MAIDEN NAME:

*Lusana Todd*15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)*no*

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

*Mrs. Nina Smith (Wife)*

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

*177X*  
Immediate cause(a) *Carcinoma of Prostate*  
DUE TO

## Antecedent causes (s)

Disease or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.(b)   
DUE TO(c) Interval Between  
Onset And Death*18 mos*

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/19*, 19*54*, to *3/15*, 19*55*, that I last saw the deceasedalive on *3/14*, 19*55*, and that death occurred at *4:05 AM* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*3-16-55*23. BURIAL, CREMATION,  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, r county)

## State

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

*3/16/55**Mr. & Mrs. George J. Kirgill Moore & Son**Newton**Newton**Quail*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 22 1955

RECEIVED

2510

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                   |  |                         |   |                 |   |            |
|---|-------------------|--|-------------------------|---|-----------------|---|------------|
| 1. PLACE OF DEATH:  |                   |  |                         | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                 |   |            |
| COUNTY <u>Caroline</u>  |                   | MARYLAND   |                         | STATE <u>Maryland</u>   |                 | COUNTY <u>Caroline</u>  |            |
| CITY (If outside corporate limits, write RURAL or and give nearest town)  |                   | LENGTH OF STAY (in this place)   |                         | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |                 |   |            |
| <u>X</u> <u>Preston - Rural</u>   |                   | <u>Life</u>  |                         | <u>Preston - Rural</u> <u>X</u>   |                 |   |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harmony</u>  |                   |  |                         | STREET ADDRESS (If rural give location) <u>Harmony</u>                        |                 |   |            |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |  |                         | 4. DATE (Month) (Day) (Year) OF DEATH:  |                 |   |            |
| <u>Harry</u> <u>Roland</u> <u>Towers</u>  |                   |  |                         | <u>March</u> <u>28</u> <u>1955</u>  |                 |   |            |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:       | 9. AGE last birthday  | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |            |
| <u>Male</u>   | <u>White</u>      | <u>Married</u>   | <u>January 31, 1887</u> | <u>68</u> yrs.  | Months          | Days  | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Farmer</u>  |                   |  |                         | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>                          |                 | 11. BIRTHPLACE (State or foreign country): <u>Caroline County, Maryland</u> |            |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                   |  |                         |   |                 |   |            |
| 13. FATHER'S NAME: <u>George W. Towers</u>  |                   |  |                         | 14. MOTHER'S MAIDEN NAME: <u>Julia E. Liden</u>                               |                 |   |            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>   |                   |  |                         | 16. SOCIAL SECURITY NO. <u>Unknown</u>  |                 | 17. INFORMANT & ADDRESS: <u>G. Chester Towers, Landover, Maryland</u>       |            |
| 18. MEDICAL CERTIFICATION   |                   |  |                         |   |                 | INTERVAL BETWEEN ONSET AND DEATH  |            |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                         |   |                 |   |            |
| 420.1 IMMEDIATE CAUSE   |                   |  |                         |   |                 |   |            |
| (A) <u>Acute Coronary Occlusion</u>   |                   |  |                         |   |                 | <u>Immediate</u>  |            |
| ANTECEDENT CAUSE (S)  |                   |  |                         |   |                 |   |            |
| (B) <u>Coronary Sclerosis &amp; Insufficiency</u>   |                   |  |                         |   |                 | <u>10 yrs</u>   |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.  |                   |  |                         |   |                 |   |            |
| 260X (C) <u>Generalized Arteriosclerosis</u>  |                   |  |                         |   |                 | <u>10 yrs</u>   |            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus (Insulin)</u>   |                   |  |                         |   |                 | <u>10 yrs</u>   |            |
| 19A. DATE OF OPERATION: <u>✓</u>  |                   |  |                         | 19B. MAJOR FINDINGS OF OPERATION: <u>✓</u>                                    |                 |   |            |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   |  |                         |   |                 |   |            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                         | 21C. WHERE DID (City or town) (County) (State)                                |                 | INJURY OCCUR?   |            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                         | 21F. HOW DID INJURY OCCUR?  |                 |   |            |
| 22. I hereby certify that I attended the deceased from <u>1/10</u> , 19 <u>55</u> , to <u>3/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>55</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. |                   |  |                         |   |                 |   |            |
| SIGNATURE <u>Lucy B. Plummer</u>  |                   | M.D. <u>Preston Md</u>   |                         | DATE SIGNED <u>3/28/55</u>  |                 |   |            |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF   |                         | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State)                                    |            |
| <u>Burial</u>   |                   | <u>March 31, 1955</u>  |                         | <u>Linchester Cemetery</u>  |                 | <u>Preston, Maryland</u>  |            |
| DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>  |                   | REGISTRAR'S SIGNATURE <u>Cornelia W. Plummer</u>   |                         | 24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>          |                 | ADDRESS   |            |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNTING V. S.

APR 1

R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2511

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02498

Reg. Dist. No. 64

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Caroline</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Ad.</u> COUNTY <u>Caroline</u>   |   |
| CITY (If outside corporate limits, write RURAL and OR give nearest town)<br><input checked="" type="checkbox"/> TOWN <u>rural</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Federalsburg</u> <input checked="" type="checkbox"/>                              |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Federalsburg</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>rural Allen Corner Rd.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>John E. Towers</u>   |                                  | 4. DATE OF DEATH <u>Mar. 29, 1955</u>   |   |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>   | 8. DATE OF BIRTH<br><u>May 12, 1875</u> |
| 9. AGE last birthday <u>79</u> yrs.  |                                  | 10. If under 1 year Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired farmer</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Abraham Towers</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah (last name unknown)</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY No.<br><u>yes</u>   |   |
| 17. INFORMANT AND ADDRESS<br><u>J. Elwood Towers Federalsburg, Md.</u>   |                                  |   |   |
| 18. MEDICAL CERTIFICATION  |                                  |   |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 116.8 Immediate cause (a) <u>Asphyxiation</u><br>Antecedent cause(s) (b) <u>Trapped in burning building</u><br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)                          |                                  | <u>See notes</u>  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                                  |   |   |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                  |   |   |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE <u>accident</u>  |                                  | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Federalsburg</u> COUNTY <u>Caroline</u> (STATE) <u>MD</u>                    |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-29-55 2<sup>nd</sup> m.</u>  |                                  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Trapped in burning building</u> |   |
| 22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>1955</u> , that I last saw the deceased alive on <u>March 30, 1955</u> , and that death occurred at <u>2:00</u> m., from the causes and on the date stated above. |                                  |   |   |
| SIGNATURE <u>Thomas D. George, Deputy Medical Examiner, Annapolis</u>  |                                  | ADDRESS <u>Smithston Cemetery near Preston, Md.</u>   |   |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>  |                                  | DATE THEREOF <u>3/31/55</u>   |   |
| DATE REC'D BY LOCAL REG. <u>March 30, 1955</u>   |                                  | REGISTRAR'S SIGNATURE <u>W. H. Miller, Deputy Registrar</u>   |   |
| 24. FUNERAL DIRECTOR   |                                  | ADDRESS <u>Federalsburg, Md.</u>  |   |

5 A 070805

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2512

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|  |  |                                |  |  |  |                                  |  |
|--|--|--------------------------------|--|--|--|----------------------------------|--|
| 1. PLACE OF DEATH:   |  |                                |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |                                  |  |
| COUNTY <u>Caroline</u>   |  | MARYLAND                       |  | STATE <u>md</u>  |  | COUNTY <u>Caroline</u>           |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place) |  | CITY (If outside corporate limits, write RURAL and give nearest town)  |  | OR TOWN                          |  |
| <u>X</u> <u>Denton</u>   |  | <u>Wife</u>                    |  | <u>Denton</u>  |  | <u>X</u>                         |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>405 High st</u>   |  |                                |  | STREET ADDRESS (If rural give location) <u>405 High st.</u>  |  |                                  |  |
| 3. NAME OF DECEASED:   |  |                                |  | 4. DATE (Month) (Day) (Year)   |  |                                  |  |
| (First) (Middle) (Last) <u>William R Troxon</u>  |  |                                |  | OF DEATH <u>3</u> <u>20</u> <u>1955</u>  |  |                                  |  |
| 5. SEX: <u>Male</u>  |  | 6. COLOR OR RACE: <u>Col</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>  |  | 8. DATE OF BIRTH: <u>3/14/98</u> |  |
| 9. AGE last birthday: <u>57</u> yrs  |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS.   |  | IF UNDER 1 YEAR                  |  |
|  |  | Months                         |  | Days   |  | Hours                            |  |
|  |  |                                |  |  |  | Min.                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant Store owner</u>   |  |                                |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>   |  |                                  |  |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>   |  |                                |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |                                  |  |
| 13. FATHER'S NAME: <u>Elijah Troxon</u>  |  |                                |  | 14. MOTHER'S MAIDEN NAME: <u>Mary Bosley</u>   |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>—</u>   |  |                                |  | 16. SOCIAL SECURITY NO. <u>—</u>   |  |                                  |  |
| 17. INFORMANT & ADDRESS: <u>Elych Troxon-Denton</u>  |  |                                |  |  |  |                                  |  |
| 18. MEDICAL CERTIFICATION  |  |                                |  |  |  |                                  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |                                |  |  |  |                                  |  |
| 420.1 IMMEDIATE CAUSE  |  |                                |  | (A) <u>Coronary Occlusion</u>  |  |                                  |  |
| ANTECEDENT CAUSE (B)   |  |                                |  | DUE TO <u>Coronary Occlusion</u>   |  |                                  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |                                |  | (B) <u>Coronary Occlusion</u>  |  |                                  |  |
|  |  |                                |  | (C) <u>Arteriosclerosis</u>  |  |                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>   |  |                                |  |  |  |                                  |  |
| 19A. DATE OF OPERATION:  |  |                                |  | 19B. MAJOR FINDINGS OF OPERATION   |  |                                  |  |
|  |  |                                |  |  |  |                                  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                |  |  |  |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |                                |  | 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)   |  |                                  |  |
|  |  |                                |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |                                  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |                                |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |                                  |  |
|  |  |                                |  | 21F. HOW DID INJURY OCCUR?   |  |                                  |  |
| 22. I hereby certify that I attended the deceased from <u>3-10, 1955</u> to <u>3-30, 1955</u> that I last saw the deceased alive on <u>3-30, 1955</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above. |  |                                |  |  |  |                                  |  |
| SIGNATURE <u>Dawson George</u>   |  |                                |  | ADDRESS <u>Denton Md</u>   |  |                                  |  |
| DATE SIGNED <u>4/2/55</u>  |  |                                |  |  |  |                                  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  |                                |  | DATE THEREOF <u>4/3/55</u>   |  |                                  |  |
| NAME OF CEMETERY OR CREMATORY <u>Sand town</u>   |  |                                |  | LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>  |  |                                  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>4-2-55</u>  |  |                                |  | REGISTRAR'S SIGNATURE <u>Wm B Gane</u>   |  |                                  |  |
| FUNERAL DIRECTOR <u>Joe P. Ashwell</u>   |  |                                |  | ADDRESS <u>Denton Md</u>   |  |                                  |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 8 11 12

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02500

2513

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <i>Caroline</i> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <i>Delaware</i> COUNTY <i>New Castle</i>                     |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <i>Ridgely, Md. Rural</i> LENGTH OF STAY (in this place) <i>17 mo.</i> |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <i>Townsend</i> <i>X-3</i> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>10</i>  |                                  | STREET ADDRESS (If rural, give location)<br><i>Delaware R.D. 1</i>  |  |
| 3. NAME OF DECEASED (Type or Print)<br>(First) <i>Matthie</i> (Middle) <i>J.</i> (Last) <i>Van Horn</i>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><i>3-22-1955</i>   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i>   | 8. DATE OF BIRTH<br><i>11-30-1867</i>                    |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday<br><i>86</i> yrs.                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><i>Del.</i> |
| 13. FATHER'S NAME<br><i>Hanson Harris</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Rubeca Mary</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                                  | 16. SOCIAL SECURITY No.   |  |
| 17. INFORMANT AND ADDRESS<br><i>Dejens, Hockley Townsend</i>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH                         |  |
| 450. Immediate cause   |  | (a) <i>Myocardial Infarction, acute</i>  |  | 3 days   |  |
| Antecedent cause(s)  |  | (b) <i>Atherosclerosis, Generalized</i>  |  | years  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last |  | (c) <i>Atherosclerosis, Generalized - Sclerosis</i>  |  | 4 years  |  |
| II. OTHER SIGNIFICANT CONDITIONS   |  | 19. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?   |  |
| Conditions contributing to the death but not related to the disease or condition causing death.  |  | <i>Dehydration - Pericarditis</i>  |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | PLACE (Home, farm, factory, street, OF office hldg., etc.)   |  | (CITY OR TOWN) (COUNTY) (STATE)                          |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> |  | HOW DID INJURY OCCUR?                                    |  |

22. I hereby certify that I attended the deceased from *Feb.*, 19*53*, to *3-22-*, 19*55*, that I last saw the deceased alive on *3-22-*, 19*55*, and that death occurred at *3:45 P.* m., from the causes and on the date stated above.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| SIGNATURE<br><i>James H. Vincent M.D.</i>                   |  | ADDRESS<br><i>Ridgely, Maryland</i>         |  | DATE SIGNED<br><i>3-23-55</i>                           |  |
| 23. BURIAL CREMATION REMOVAL (Specify)<br><i>Burial</i>     |  | DATE<br><i>3-25-55</i>                      |  | NAME OF CEMETERY OR CREMATORY<br><i>Bethel Cemetery</i> |  |
| LOCATION (City, town, or county)<br><i>Chapin City, Md.</i> |  | (State)<br><i>Del.</i>                      |  | 24. FUNERAL DIRECTOR<br><i>Wm. J. ...</i>               |  |
| DATE REC'D BY LOCAL REG.<br><i>Mar. 23, 1955</i>            |  | REGISTRAR'S SIGNATURE<br><i>Mary C. ...</i> |  | 24. FUNERAL DIRECTOR<br><i>Wm. J. ...</i>               |  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.

MAR



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2514 CERTIFICATE OF DEATH

02502

Reg. Dist. No. 41

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>Caroline</u>  | MARYLAND   | STATE <u>Maryland</u>  | COUNTY <u>Caroline</u>                      |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Greensboro</u>                  | LENGTH OF STAY (in this place)<br><u>72 Yrs.</u> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Greensboro</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>None</u>  |  | STREET ADDRESS (If rural give location)<br><u>None</u>   |   |
| 3. NAME OF DECEASED:  |  | 4. DATE (Month) (Day) (Year)   |   |
| (First) <u>Wilmer</u>   | (Middle)   | (Last) <u>Webber</u>   | DATE OF DEATH: <u>3</u> <u>16</u> <u>55</u> |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u>                   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>                                   | 8. DATE OF BIRTH: <u>5/8/1882</u>           |
| 9. AGE last birthday <u>72</u> yrs.   |  | 10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.                                       |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Laborer</u> |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>   |   |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME: <u>William Webber</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Maggie Todd</u>   |   |
| 15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>     |  | 16. SOCIAL SECURITY No. <u>220-03-3557 A</u>   |   |
| 17. INFORMANT & ADDRESS: <u>Katie Webber Greensboro, Md.</u>  |  |  |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |                                  |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>   |  |                                  |
| ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease</u>  |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                        |  |                                  |
| (C)  |  |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |  |                                  |

|                         |                                  |   |
|-------------------------|----------------------------------|---|
| 19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|-------------------------|----------------------------------|---|

|  |  |  |
|--|--|--|
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) |
|--|--|--|

|   |  |                            |
|---|--|----------------------------|
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from June 1, 1954 to Mar. 16, 1955, that I last saw the deceased alive on Mar. 16, 1955, and that death occurred at 7 A.M. from the causes and on the date stated above.

SIGNATURE Charles H. Hensley ADDRESS Greensboro, Md. DATE SIGNED March 17, 1955

|  |                |                               |  |
|--|----------------|-------------------------------|--|
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF   | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u>                            | <u>3/19/55</u> | <u>Greensboro</u>             | <u>Greensboro, Md.</u>                   |

|                               |                       |                      |                        |
|-------------------------------|-----------------------|----------------------|------------------------|
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | LOCAL DIRECTOR       | ADDRESS                |
| <u>Mar. 19-1955</u>           | <u>L. M. Lippin</u>   | <u>J. E. Boulaie</u> | <u>Greensboro, Md.</u> |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 23 1955

RECEIVED

2515

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

|  |                            |   |                                       |   |                                      |  |  |
|--|----------------------------|---|---------------------------------------|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH:   |                            |   |                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                      |                                      |  |  |
| COUNTY <u>Caroline</u>   |                            | MARYLAND  |                                       | STATE <u>Maryland</u>   |                                      | COUNTY <u>Caroline</u>                                     |  |
| CITY (If outside corporate limits, write name of town) <u>Ridgely</u>                                      |                            | LENGTH OF STAY (in this place) <u>50 yrs</u>                    |                                       | CITY (If outside corporate limits, write name of town) <u>Ridgely</u>       |                                      | LENGTH OF STAY (in this place) <u>50 yrs</u>               |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                            |   |                                       | STREET ADDRESS (If rural give location)                                     |                                      |  |  |
| 3. NAME OF DECEASED: (Type or Print) <u>James P. Wilson</u>  |                            |   |                                       | 4. DATE OF DEATH: (Month) <u>Mar</u> , (Day) <u>15</u> , (Year) <u>1955</u> |                                      |  |  |
| 5. SEX: <u>M</u>   | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>Dec 14, 1877</u> | 9. AGE last birthday: <u>77</u> yrs.  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. |  |  |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Mechanic</u> |                            |   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Flour mill</u>                        |                                      | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> |  |
| 13. FATHER'S NAME: <u>James P. Wilson</u>  |                            |   |                                       | 14. MOTHER'S M maiden name: <u>Mary Swann</u>                               |                                      |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>                                   |                            |   |                                       | 16. SOCIAL SECURITY No.: <u>216-10-1840</u>                                 |                                      | 17. INFORMANT & ADDRESS: <u>Elma Wilson, Ridgely, Md.</u>  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. MEDICAL CERTIFICATION  |  |   |  | Interval Between Onset And Death   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |
| Immediate cause (a) <u>Carcinoma of the bladder.</u>   |  |   |  |  |  |
| Antecedent causes (s) (b) <u>Hypertension</u>  |  |   |  |  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>  |  |   |  |  |  |
| 11. OTHER SIGNIFICANT CONDITIONS   |  |   |  |  |  |
| Conditions contributing to the death but not related to the disease or condition causing death. <u>2 Central arteriosclerosis</u>  |  |   |  |  |  |
| 12. DATE OF OPERATION: <u>Mar 14, 1955</u>   |  | 13. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of bladder - moderately invasive</u>                |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 21. ACCIDENT (Specify) <u>HOMICIDE</u>   |  | PLACE (Home, farm, factory, street, office bldg., etc.) <u>Office bldg.</u>                       |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>Mar 14, 1955</u> , to <u>Mar 15, 1955</u> that I last saw the deceased alive on <u>Mar 14, 1955</u> , and that death occurred at <u>about 2 AM</u> , from the causes and on the date stated above. |  |   |  |  |  |
| SIGNATURE <u>Charles A. Unice</u>  |  | DATE SIGNED <u>Mar 17, 1955</u>   |  | ADDRESS <u>Ridgely, Md.</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | DATE THEREOF <u>Mar 18, 1955</u>  |  | NAME OF CEMETERY OR CREMATORY <u>Greenboro</u>                                   |  |
| DATE REC'D BY LOCAL REGISTRAR <u>Mar 17, 1955</u>  |  | REGISTRAR'S SIGNATURE <u>Mary E. Landry</u>   |  | 24. FUNERAL DIRECTOR <u>J. T. G. Moore &amp; Son, Inc.</u>                       |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 21 1955

RECEIVED